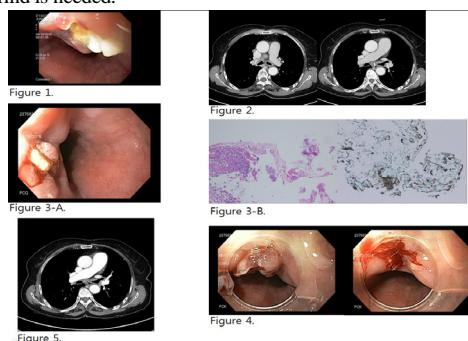


Esophageal actinomycosis associated with foreign body in a healthy patient: A case report

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Introduction: Actinomycosis is a rare invasive bacterial disease caused by actinomyces spp. that are anaerobic gram-positive bacilli colonize the human mouth and gastrointestinal tract, genital tract. Especially in esophagus, actinomycosis is very rare and patients are usually immunosuppressed. Actinomycosis can be diagnosed by gram staining of pus and pathology of infected tissue characterized by sulfur granule. In this review, we report a case of esophageal actinomycosis caused by foreign body in a healthy patient. **Case report:** A healthy 74-year-old woman had sore throat and cough, and went to the local medical center. She underwent esophagogastroduodenoscopy(EGD), and an esophageal ulcer was founded.(Figure 1.) A biopsy finding was actinomycosis. Then she was referred to our hospital. Symptoms were still remained. Chest CT scan showed diffuse enhancing soft tissue density in subcarinal area with suspicious penetrative linear calcification to esophageal lumen, subcarinal lymph node.(Figure 2.) EGD was performed and we found irregular ulcer with central foreign body in esophagus.(Figure 3-A.) A biopsy finding was chronic ulcer with sulfur granule, consistent with actinomycosis.(Figure 3-B.) We prescribed antibiotics for 4 weeks and after medication the patient revisited our hospital and symptoms were subsided. We prescribed more antibiotics for 1 week and planned EGD to remove foreign body. The patient underwent EGD, bluish polypoid lesion was founded but foreign body was disappeared. We did massive repeated biopsy, but we couldn't find it. (Figure 4.) We took a chest CT and finding was high density linear lesion was disappeared and a lesion was founded that seemed to be a esophagocutaneous fistula. (Figure 5.) We suggested that the foreign body was removed spontaneously. **Conclusion:** Actinomycosis can occur in nearly any part of the body, but in esophagus, as we described, is very rare even in immunocompetent patient, caused by foreign body. We think this case has value to report in this point. In actinomycosis patients, we should consider the possibility of foreign body and careful approach to find is needed.



Primary Closure of Colon Perforation with Endoscopic Band Ligation and Subsequent Endoclippping

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Background: Increasing use of colonoscopy for health check up and treatment of some colonic disease, inevitably elevates the probability of colon perforation. We report a case of primary closure of sigmoid colon perforation with Endoscopic Band Ligation and subsequent Endoclippping. **Case:** A 63 year old woman underwent colonoscopy and at rectosigmoid junction, a perforation was developed. She was transferred to our hospital for closure of perforated colon. Abdomen-Pelvis computed tomography showed pneumoperitoneum, pneumoretroperitoneum, pneumomediastinum, pneumopericardium. Colonoscopy found a hole at rectosigmoid junction. Endoscope was changed from Colonoscope to Gastroscope. Endoscope aspirated perforated lesion into the suction cup and a elastic band was applied around the base of the aspirated lesion. The hole wasn't closed completely by single band ligation therefore subsequent endoscopic clipping was done to seal the remnant hole beside the ligated band. The patient had nothing per oral for 1 week and given antibiotics. On day 14 when she could have tolerable diet, she was discharged. **Conclusion:** Traditional Endoscopic clipping for closure of iatrogenic colon perforation is sometimes not proper for perforation greater than 10mm in diameter. By using Band ligation and subsequent endoclippping, large colon perforation greater than 10mm could be relatively easily closed compared to using endoscopic clipping or band ligation alone. **Implication:** 1. Our experience suggests that studies, for establishing the right criteria on the size of colon perforation that can be covered with Band Ligation and subsequent endoscopic clipping, needs to be performed. 2. Endoscopic closure of colon perforation was done approximately 6 hours after perforation was developed. In our experience, if bowel preparation for colonoscopy is done excellently, Endoscopic closure of colon perforation is recommendable even 6 hours later after perforation was developed.

